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Issue Date: 27 September 2005

In the Matter of:
ERNEST FUSON
Claimant

Case No.: 2004 BLA 6301

v.

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances: Mr. John Grigsby, Attorney
For the Claimant

Ms. Theresa Ball, Attorney
For the Director

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER – AWARD OF BENEFITS

This matter involves a claim filed by Mr. Ernest Fuson for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural Background

First Claim
(DX 1)[1]

Initial Claim

Mr. Fuson filed his first application for black lung disability benefits on June 15, 1970. On September 29, 1970, his claim was denied by the Social Security Administration ("SSA"), the agency responsible for administering Black Lung benefits at that time. On July 18, 1973, after the regulations were amended in 1972, SSA reexamined Mr. Fuson's case and again denied

[1]The following notations appear in this decision to identify exhibits: DX – Director exhibit; ALJ – Administrative Law Judge exhibit; CX – Claimant exhibit; and, TR – Transcript.

his claim. In response, Mr. Fuson requested an administrative hearing; however, he subsequently agreed to have his claim decided on the record. On December 3, 1975, Administrative Law Judge H. J. Lincoln disallowed Mr. Fuson's claim because he appeared to still be employed as a coal miner.

In November 1978, due to another revision to the Act, Mr. Fuson elected to have his denied claim reviewed by U.S. Department of Labor ("DOL"). In February 1980, Mr. Fuson also completed another claim form. On October 23, 1980, DOL denied Mr. Fuson's claim because he failed to establish the presence of pneumoconiosis or total disability. Through counsel, Mr. Fuson appealed the adverse determination. Subsequently, due to 1981 amendments to the Act, the named responsible operator was released in 1983 and responsibility for the case was transferred to the Black Lung Trust Fund. Eventually, on July 12, 1985, the case was referred to the Office of Administrative Law Judges ("OALJ"). After conducting a hearing in July 1987, Administrative Law Judge Clement Kichuk issued a decision on January 19, 1988, denying Mr. Fuson's claim for failure to prove the presence of pneumoconiosis and total disability. Mr. Fuson appealed to the Benefits Review Board ("BRB" or "Board"). The BRB affirmed the denial on January 26, 1990. Mr. Fuson did not appeal and the decision therefore became final on February 26, 1990.

Modification

Mr. Fuson submitted another black lung disability claim form on March 27, 1990. Since the claim was filed less than a year after the BRB decision, DOL treated the claim as a request for modification of the denial decision. Mr. Fuson's claim was initially denied by the District Director, and upon his request forwarded to the OALJ for a hearing. However, Mr. Fuson subsequently withdrew the claim when he became aware of the offset provisions relating to his state black lung disability benefits. On June 19, 1992, Judge Bernard Gilday, Jr. issued an Order authorizing the withdrawal of the claim.[2]

Second, and Present Claim

On March 26, 2003, Mr. Fuson filed his second claim for black lung disability benefits (DX 3). On November 17, 2003, the District Director determined that Mr. Fuson would not be entitled to benefits at that time; however, the parties were provided an additional opportunity to submit evidence (DX 15). After consideration of additional medical evidence, on March 3,

[2]According to 20 C.F.R. § 725.306 (b), a claim that has been withdrawn by a claimant is considered not to have been filed. Notably absent in that regulatory language is any other limitation on the approval authority. However, in *Lester v. Peabody Coal Company*, 22 BLR 1-183 (2002), and *Clevenger v. Mary Helen Coal Company*, 22 BLR 1-193 (2002), the Benefits Review Board ("BRB") restricted the extent of claim withdrawal approval authority. In both *Lester*, 22 BLR at 1-191, and *Clevenger*, 22 BLR at 1-200, the BRB stated ". . .the provisions at Section 725.306 are applicable only up until such time as a decision on the merits issued by an adjudication officer becomes effective." Since Mr. Fuson did not submit a timely appeal of the BRB's January 1990 denial of his claim, the denial of the initial claim became final and that initial claim could not be withdrawn. On the other hand, adjudication of the March 1990 modification request was not final. Consequently, based on Judge Gilday's approval, I consider that March 1990 modification request and corresponding evidence to have been withdrawn and I will not consider the evidence associated with the modification request.

2004, the District Director issued a Proposed Decision and Order denying benefits to Mr. Fuson for failure to establish any of the requisite elements of entitlement (DX 17). Mr. Fuson timely appealed, requesting a hearing before OALJ (DX 18), and on May 18, 2004, the case was forwarded to OALJ. Pursuant to a Notice of Hearing, dated June 22, 2004, I conducted a hearing on September 22, 2004 in Knoxville, Tennessee,[3] attended by Mr. Fuson, Mr. Grigsby and Ms. Ball. My decision in this case will be based on all the evidence in the record: DX 1 to DX 19, CX 1, and CX 2.[4]

ISSUES

1. Whether Mr. Fuson in filing a subsequent claim on March 26, 2003 has demonstrated that a change has occurred in one of the conditions, or elements, of entitlement, upon which the denial of his prior claim was based in February 1990.

2. If Mr. Fuson establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated to the following facts: a) Mr. Fuson was a coal miner with post-1969 coal mine employment; b) his length of coal mine employment was at least 19 years and six months; and, c) Mrs. Catherine Fuson is a dependent for the purpose of augmenting any benefits that may be payable (TR, pages 8, 9 and 14).

Preliminary Findings

Born on August 11, 1914, Mr. Fuson married Mrs. Catherine Fuson on May 27, 1944. Mr. Fuson worked in the mines for 27 years[5], all of which was underground, beginning in 1950. During his mining career, he shot and drilled coal, operated machines and hung machine cables at the face of the mine. When he stopped mining coal around 1975, he was operating a coal-cutting machine. This job required Mr. Fuson to cut coal and then operate a drill, which weighed about 85 pounds and needed to be handled by two men. In accomplishing these tasks, he had to lift the drill and work with machine cables that were as long as 350 feet. Mr. Fuson stopped working in the coal mines when a physician informed him that he should not continue working in

[3]This case is subject to the jurisdiction of the United States Court of Appeals for the Sixth Circuit.

[4]A portion of DX 16 contains the 1979 depositions of Dr. Anderson, Dr. Penman and Dr. O'Neil. A subsequent claim requires a claimant to show that an applicable condition of entitlement has changed since the last claim was denied. Since Mr. Fuson's last claim was denied in February 1990, I will not consider those medical opinions on the issue of change in condition of entitlement.

[5]At the hearing, Mr. Fuson recollected working in the coal mines for 28 years. In his initial claim, Judge Kichuk determined that Mr. Fuson had 27 years of coal mine employment and the Benefits Review Board affirmed that finding.

the mines because his "lungs [were] bad" and he was at risk for a heart attack (DX 3, DX 10, TR, pages 15 to 26).

At the time of the hearing, Mr. Fuson had persistent and chronic breathing problems. He used a breathing machine 24 hours per day in addition to taking other breathing medications. He also has had episodes of pneumonia. Mr. Fuson had not smoked cigarettes smoke except for a brief period of four weeks sometime in the 1940's (TR, pages 21 to 31). Regretfully, I received notice on August 28, 2005 from Mr. Grigsby that Mr. Fuson passed away on May 22, 2005.

Issue #1 – Change in Applicable Condition of Entitlement

After the expiration of one year from the denial of benefits, the submission of additional material or another claim is considered a subsequent claim which will be considered under the provisions of 20 C.F.R. § 725.309 (d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied ("applicable condition of entitlement") has changed and is now present. If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties 20 C.F.R. § 725.309 (d) (4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

In adjudicating a subsequent claim in which the applicable conditions of entitlement relate to the miner's physical condition, I focus on the four basic conditions, or elements, a claimant must prove by preponderance of the evidence to receive black lung disability benefits under the Act. First, the miner must establish the presence of pneumoconiosis.[6] Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.[7] Third, the miner has to demonstrate he is totally disabled.[8] And fourth, the miner must prove the total disability is due to coal workers' pneumoconiosis.[9]

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[6] 20 C.F.R. § 718.202.

[7] 20 C.F.R. § 718.203 (a).

[8] 20 C.F.R. § 718.204 (b).

[9] *Id*

With those four principle conditions of entitlement in mind, the next adjudication step requires the identification of the conditions of entitlement a claimant failed to prove in the prior claim. In that regard, of the four principle conditions of entitlement, the two elements that are usually capable of change are whether a miner has pneumoconiosis or whether he is totally disabled. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997). That is, the second element of entitlement (pneumoconiosis arising out of coal mine employment) and the fourth element (total disability due to pneumoconiosis) require preliminary findings of the first element (presence of pneumoconiosis) and the third element (total disability).

In Mr. Fuson's case, his prior claim was finally denied in February 1990 for failure to prove the presence of pneumoconiosis and total disability. Consequently, for purposes of adjudicating the present subsequent claim, I will evaluate the evidence developed since July 1987 when the record in Mr. Fuson's initial claim closed to determine whether Mr. Fuson can now prove total disability or the presence of pneumoconiosis.

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204 (b) (1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

Mr. Fuson has not presented evidence of cor pulmonale with right-sided congestive heart failure and the record contains no evidence of complicated pneumoconiosis. As a result, Mr. Fuson must demonstrate total respiratory, or pulmonary, disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV¹ pre[10] post[11]	FVC pre post	MVV pre post	% FEV¹ / FVC pre post	Qualified[12] pre Post	Comments
DX 12	Sept. 9, 2003 Dr. Baker	84[13] 61 ½"	1.10	1.97	73	55.4%	Yes[14]	Mild, restrictive defect; questionable effort. (Invalid per Dr. Michos)
DX 12	Oct. 17, 2003 Dr. Baker	84 61 ½"	1.37	1.97	69	69.5%	No	Within normal limits

Although one of the two pulmonary function tests produced qualifying results, Mr. Fuson is not able to establish that he is totally disabled through this method. First, the qualifying test was determined to be invalid by Dr. Michos. Second, a contemporaneous pulmonary function test that was valid did not produce qualifying results. Thus, even if the September 2003 test had been valid, the subsequent October 2003 study would have placed in the pulmonary function test evidence in equipoise, which does not represent a preponderance of evidence. As a result, I find that Mr. Fuson can not establish total disability under 20 C.F.R. §§ 718.204 (b) (1) and (2) (i).

[10]Test result before administration of a bronchodilator.

[11]Test result following administration of a bronchodilator.

[12]Under 20 C.F.R. § 718.204 (b)(2)(i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV^1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV^1/FVC has to be equal to or less than 55%.

[13] For all of the pulmonary function tests taken, I am using the highest age listed in the regulations, Appendix B, Table B1 of 20 C.F.R. §718 of 71 years.

[14]The qualifying FEV^1 number is 1.20 for age 71and 61.4″; the corresponding qualifying FVC and MVV values are 1.57 and 48, respectively.

Arterial Blood Gas Study

Exhibit	Date / Doctor	pCO_2 (rest) pCO_2 (exercise)	pO_2 (rest) pO_2 (exercise)	Qualified[15]	Comments
DX 12	Sept. 9, 2003 Dr. Baker	40	52	Yes[16]	Severe hypoxemia (Valid per Dr. Michos)

Under the provisions of 20 C.F.R. §718.204 (b) (2) (ii), if the preponderance of the arterial blood gas studies qualify under Appendix C of Section 718, then in the absence of evidence to the contrary, the blood gas evidence shall establish a miner's total disability. Adjudication under this regulatory section requires a five step process.

First, an administrative law judge must determine whether the tests conform to the arterial blood gas study procedural requirements in 20 C.F.R. §718.105. Second, the results are compared to the qualifying values for the various tests listed in Appendix C to determine whether the test qualifies. Third, an administrative law judge must evaluate any medical opinion that questions the validity of the test results. Fourth, a determination must be made whether the preponderance of the conforming and valid arterial blood gas studies supports a finding of total disability under the regulation. Fifth, if the preponderance of conforming tests establishes total disability, an administrative law judge then reviews all the evidence of record and determines whether the record contains "contrary probative evidence." If there is contrary evidence, then it must be given appropriate evidentiary weight and a determination is made to see if it outweighs the pulmonary function tests that support a finding of total respiratory disability. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987).

With these guidelines in mind, I first observe that the qualifying test appears to conform to procedural requirements and no challenge to its validity has been presented. Next, since the only arterial blood gas study in evidence produced a result that meets the regulatory requirements for establishing total disability, the September 9, 2003 arterial blood gas study supports a finding of total disability.

In terms of contrary evidence, the equivocal pulmonary function tests which measure a different function of pulmonary capacity – pulmonary ventilation – do not represent contrary evidence to the arterial blood gas study showing a blood oxygenation deficiency.

Turning to medical opinion, as discussed in later detail, the three physicians who most recently treated Mr. Fusion essentially agreed that he had a totally disabling impairment due in part to his exposure to coal dust. Thus, the consensus of the contemporaneous medical opinion supports, rather than contraindicates, a finding to total respiratory disability.

[15]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO_2 level, the value of the coal miner's pO_2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[16]For the pCO_2 of 40 to 49, the qualifying pO_2 is 60, or less.

Consequently, in the absence of sufficient probative contrary evidence, Mr. Fuson has proven through arterial blood gas study evidence developed since the denial of his prior claim that he is now totally disabled. Having established that one of the conditions of entitlement that he previously failed to prove has changed and is now present, Mr. Fuson has satisfied the provisions of 20 C.F.R. §725.309. As a result, I must now examine the entire medical record to determine whether Mr. Fuson is entitled to black lung disability benefits.

Issue #2 – Entitlement to Benefits

As previously summarized, to receive benefits under the Act, a claimant must prove by preponderance of the evidence: 1) the presence of pneumoconiosis; 2) pneumoconiosis due to coal mine employment; 3) total disability; and, 4) total disability due to coal workers' pneumoconiosis.

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[17] The regulatory definitions include both a) clinical, or medical pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis; and, b) legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[18] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201 (b). As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

Under the regulation, 20 C.F.R. § 718.201 (a) (1), clinical pneumoconiosis has two components: a) "permanent deposition of substantial amount of particulate matter in the lungs," and, b) "fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment." This regulatory definition also specifically includes "anthracosis."

According to 20 C.F.R. §718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),[19] and medical opinion (§ 718.202 (a)(4)). Since the record does not contain evidence that Mr. Fuson had complicated pneumoconiosis, and he filed his claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable.

[17]20 C.F.R. § 718.201 (a).

[18]20 C.F.R. § 718.201 (a)(1) and (2).

[19]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

Additionally, neither biopsy nor autopsy evidence has been introduced in this case. As a result, Mr. Fuson will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis.

Chest X-Rays

The following table summarizes all chest x-ray interpretations admitted into evidence.

Date of x-ray	**Exhibit**	**Physician**	**Interpretation**
August 3, 1973	DX 1	Dr. B. Jones	Positive for pneumoconiosis, profusion category 1/1[20] type p opacities,[21] calcified densities present
(same)	DX 1	Dr. B. Gayler, B, BCR[22]	Completely negative for pneumoconiosis
December 12, 1978	DX 1	Dr. Penman	Positive for pneumoconiosis, profusion category 1/2, type p opacities
(same)	DX 1	Dr. O'Neill	Positive for pneumoconiosis, profusion category 1/1, type p/q opacities; bilateral reticulonodular infiltrate in mid and lower lung zones
August 14, 1979	DX 1	Dr. Gordonson, B, BCR	(Unreadable copy)
(same)	DX 1	Dr. E. Davis	Bilateral pneumonia
February 8, 1980	DX 1	Dr. Sargent, B, BCR	Completely negative for pneumoconiosis
(same)	DX 1	Dr. T. Simmons	Negative for pneumoconiosis, profusion category 0/1, mildly accentuated marking without active disease of the chest
April 23, 1985	DX 1	Dr. R. Elmer, B, BCR	Completely negative for pneumoconiosis

[20]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2.

[21]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

[22]The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may posses to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202 (a) (1) (ii).

(same)	DX 1	Dr. Sargent, B, BCR	Negative for pneumoconiosis, widened aorta
(same)	DX 1	Dr. C. Williams	Positive for pneumoconiosis, profusion category 1/0, type p/s opacities, irregular fibrosis
July 1, 1987	DX 1	Dr. Matheny	Positive for pneumoconiosis, profusion category 1/1, type p/s opacities, pulmonary fibrosis present bilaterally with emphysematous changes
Sept. 9, 2003	DX 12	Dr. Baker, B	Positive for pneumoconiosis, profusion category 1/0, type t/s opacities; effusion present
(same)	DX 12	Dr. Barrett, BCR, B	Negative for pneumoconiosis; emphysema, abnormal cardiac size and effusion present
(same)	CX 2	Dr. M. Patel, BCR, B[23]	(Unreadable copy)
May 11, 2004	CX 1	Dr. M. Patel. BCR, B	Positive for pneumoconiosis, profusion category 1/1, type s/p opacities, cardiomegaly and calcified granuloma in the right lower lung

As previously adjudicated by Judge Kichuk and affirmed by the BRB, the preponderance of the early radiographic evidence from 1973 to 1987 did not establish the presence of pneumoconiosis. Specifically, the December 12, 1978 and July 1, 1987 chests x-rays were positive based on undisputed interpretations and the remaining four films of August 3, 1973, August 14, 1979, February 8, 1980, and April 23, 1985 were negative based on undisputed interpretations or the assessments of better qualified radiologists.

However, because coal workers' pneumoconiosis is a latent and progressive disease,[24] the more recent chest x-rays are particularly relevant. The September 9, 2003 chest x-ray produced a dispute between the two physicians who interpreted the film. Dr. Baker, a B reader, believed the film was positive for pneumoconiosis. However, Dr. Barrett, who is a board certified radiologist and B reader, did not find pneumoconiosis. Since Dr. Barrett is a dual qualified radiologist, his interpretation is more probative; and, therefore the September 9, 2003 film is negative for pneumoconiosis. On the other hand, Dr. Patel, who is as well qualified as Dr. Barrett, found evidence of pneumoconiosis in the most recent film of May 11, 2004. Dr. Patel's undisputed interpretation renders the May 11, 2004 chest x-ray positive for pneumoconiosis.

Due to the contemporaneous nature of the two most recent x-rays, a evidentiary standoff exists; one film is negative and one film is positive. Due to this evidentiary equipoise, I find that the more probative chest x-ray evidence is inconclusive as to the presence of pneumoconiosis. As result, Mr. Fuson can not prove the presence of pneumoconiosis through the radiographic evidence under 20 C.F.R.§ 718.202 (a) (1).

[23]As I advised the parties at the hearing (TR, page 7), I take judicial notice of Dr. Patel's board certification and have attached the board certification documentation.

[24]*See Parsons v. Wolf Creek Colleries*, 23 B.L.R. 1-___, BRB No. 02-0188 BLA (Sept. 30, 2004) (en banc) (the potential for progressivity and latency of pneumoconiosis is inherent in every case) and *Workman v Eastern Assoc. Coal Corp.,* BRB No. 02-0727 BLA (Aug. 19, 2004) (order on recon.) (en banc).

Medical Opinion

Under 20 C.F.R.§ 718.202 (a) (4), the presence of pneumoconiosis may also be shown through documented and reasoned medical opinion. Prior to summarizing the medical opinion, a review of additional pulmonary function tests and blood gas studies in the record helps place the physicians' assessments into perspective.

Additional Pulmonary Function Tests[25]

Exhibit	**Date / Doctor**	**Age / Height**	**FEV¹ pre post**	**FVC pre post**	**MVV pre post**	**% FEV¹ / FVC pre post**	**Qualified pre post**	**Comments**
DX 1	August 3, 1973 Dr. B. Jones	58 68.5"	2.16	2.87	113.6	75.3%	No[26]	
DX 1	April 23, 1985 Dr. Williams	69 63.75"	2.17	2.94	60	73.8%	No[27]	(MVV invalid)[28]

Additional Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**pCO_2 (rest) pCO_2 (exercise)**	**pO_2 (rest) pO_2 (exercise)**	**Qualified[29]**	**Comments**
DX 1	Sept. 7, 1979 Dr. Dahhan	35	77	No[30]	
DX 1	April 23, 1985 Dr. Williams	35.5 37.5	74.4 71.8	No No[31]	

[25]I am not including pulmonary function tests dated February 14, 1974 and February 8, 1980 in the summary because the test results are not listed in the format used by this office.

[26]The qualifying FEV^1 number is 1.97 for age 58 and 68.5″; the corresponding qualifying FVC and MVV values are 2.50 and 79, respectively.

[27]The qualifying FEV^1 number is 1.38 for age 69 and 63.4″; the corresponding qualifying FVC and MVV values are 1.80 and 55, respectively.

[28]Dr. Kramer found the test acceptable but believed the MVV was invalid (DX 1).

[29]To qualify for federal black lung disability benefits at a coal miner's given pCO_2 level, the value of the coal miner's pO_2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[30]For the pCO_2 of 35, the qualifying pO_2 is 65, or less.

[31]For the pCO_2 of 37, the qualifying pO_2 is 63, or less.

Dr. Boyce Jones
(DX 1)

On August 3, 1973, Dr. Jones conducted a pulmonary evaluation of Mr. Fuson. Dr. Jones noted that Mr. Fuson worked as a coal miner for 27 years inside the coal mines. The patient complained of coughs and wheezes, which worsen at night, and exertional shortness of breath. A physical examination of the chest revealed a slight restriction of the chest wall. A chest x-ray was positive for the presence of pneumoconiosis. After subsequently taking a pulmonary function test, Dr. Jones "advised [Mr. Fuson] to avoid further contact to irritating dusts."

Kentucky State Workers' Compensation Claim
(DX 9)

Mr. Fuson was found totally disabled from pneumoconiosis arising out of coal mine employment as of April 27, 1978 by the Kentucky State Board of Workers' Compensation.

Dr. Robert Penman
(DX 1 and DX 16)

In a deposition conducted on June 7, 1979, Dr. Penman testified about Mr. Fuson's pulmonary condition based on his review of a December 12, 1978 chest x-ray, which he believed was consistent with pneumoconiosis. Dr. Penman also stated that assuming Mr. Fuson worked in the coal mines for 31 years, he believed the patient had coal workers' pneumoconiosis and that he should not resume his former coal mine employment.

Dr. Richard O'Neill
(DX 1 and DX 16)

Dr. O'Neill, board certified in internal medicine, participated in a deposition on June 15, 1979 regarding Mr. Fuson's pulmonary condition. Mr. Fuson visited his office on December 12, 1978 complaining of trouble with progressive exertional dyspnea for the previous eight years. Mr. Fuson reported that he could not walk 100 yards on level ground or climb more than one flight of stairs without experiencing shortness of breath. The patient also had a chronic productive cough for many years. Mr. Fuson's medical history did not include pneumonia, tuberculosis or asthma. Dr. O'Neill noted that Mr. Fuson had worked as an underground coal miner for 29 ½ years, leaving the mines in 1978, and he had never smoked. A chest x-ray showed the presence of coal workers' pneumoconiosis. Dr. O'Neill concluded that Mr. Fuson has occupational pneumoconiosis. Moreover, the physician diagnosed chronic bronchitis and coal workers' pneumoconiosis. He also opined that Mr. Fuson was totally disabled and that "because he has coal workers' pneumoconiosis he should no longer expose himself to coal mine dust or to other noxious dusts or gases."

Dr. William H. Anderson
(DX 16)

In a June 27, 1979 deposition, Dr. Anderson, board certified in pulmonary disease and internal medicine, discussed his December 1978 pulmonary examination of Mr. Fuson. Mr. Fuson had worked 29 years as a coal miner and struggled with shortness of breath. He was also a nonsmoker. Since the chest x-ray was positive for pneumoconiosis, Dr. Anderson diagnosed coal workers' pneumoconiosis.

Dr. A. Dahhan
(DX 1)

On September 7, 1979, Dr. Dahhan, board certified in internal medicine and pulmonary diseases,[32] conducted a pulmonary examination of Mr. Fuson, who had been an underground coal miner for 30 years. Mr. Fuson is a non-smoker and complained of daily productive cough, frequent nocturnal wheezing and dyspnea on exertion. Dr. Dahhan also reported that Mr. Fuson has indications of coronary artery disease because of chest pain brought on by exertion. A physical exam revealed a normal chest. Arterial blood gas studies produced normal results. Dr. Dahhan opined that Mr. Fuson's main disability problem is due to his cardiac situation. He also noted that despite Mr. Fuson's history that suggests chronic bronchitis, his arterial blood gases are normal.

Dr. Cordell Williams
(DX 1)

On April 23, 1985, Dr. Williams evaluated Mr. Fuson's pulmonary condition. Mr. Fuson had about 35 years of coal mine employment and had performed a variety of tasks in the mines. He never smoked cigarettes. Mr. Fuson reported chronic shortness of breath for at least 10 years that has progressively gotten worse. He can walk up only 5 or 6 steps before becoming short of breath. He also coughs and wheezes when exposed to dust and experiences chest pain intermittently. Dr. Williams diagnosed pneumoconiosis based on the chest x-ray but opined that Mr. Fuson's arrhythmia that is the major cause of his difficulty.

Dr. R. B. Matheny
(DX 1)

On July 1, 1987, Dr. Matheny conducted a pulmonary evaluation of Mr. Fuson who presented with shortness of breath and smothering. Any type of work brings on Mr. Fuson's dyspnea and he can walk only 100 feet or climb half a flight of stairs before becoming short of breath. Mr. Fuson has also been wheezing for the last 15 years and has had a productive cough for ten to twelve years. He experiences chest pain with dyspnea. Mr. Fuson reported no history of cigarette smoking and a coal mine employment history of 35 years. Mr. Fuson's chest was normal at that time. Dr. Matheny believed that chest x-rays indicated the presence of

[32]I take judicial notice of Dr. Dahhan's board certification and have attached the certification documentation.

pneumoconiosis. Dr. Matheny concluded that Mr. Fuson has pneumoconiosis, chronic obstructive pulmonary disease, emphysema and cardiomegaly.

Dr. Glen Baker
(DX 12)

On September 9, 2003, Dr. Baker, board certified in internal medicine and pulmonary diseases,[33] conducted a pulmonary evaluation of Mr. Fuson who worked as a coal miner for 28 ½ years. Dr. Baker reported that Mr. Fuson smoked one pack of cigarettes per day for about one month, 65 years ago. Mr. Fuson complained of sputum, wheezing, dyspnea, and cough. He was being treated with oxygen and used a walker to move around.

The physical examination disclosed decreased breath sounds. The pulmonary function showed a mild restrictive defect. On the other hand, the arterial blood gas study revealed severe hypoxemia. Based on the abnormal x-ray and Mr. Fuson's history of coal dust exposure, Dr. Baker diagnosed coal workers' pneumoconiosis. He also diagnosed chronic bronchitis and possible congestive heart failure. Mr. Fuson's pulmonary impairment was severe with decreased ventilatory capacity, chronic bronchitis, decreased $_pO_2$ and coal workers' pneumoconiosis. All of his ailments contribute to his respiratory impairment. Additionally, Dr. Baker found that Mr. Fuson's pulmonary impairment was related to coal dust exposure. He believed that Mr. Fuson cannot perform the work of a coal miner.[34]

Dr. Richard G. Stolzfus
(DX 16)

On January 12, 2004, Dr. Stolzfus provided responses to a questionnaire regarding his treatment of Mr. Fuson. Dr. Stolzfus had last seen Mr. Fuson in December 2002 and treated him a few years earlier as well. Dr. Stolzfus diagnosed emphysema and chronic interstitial lung disease. Based on Mr. Fuson's 28 ½ year coal mine employment history, severe exercise impairment and need for continuous oxygen, the physician also diagnosed a chronic lung disease secondary to coal mine employment. Dr. Stolzfus believes that Mr. Fuson has a severe respiratory impairment, which is disabling and "would prevent him from performing any work on a sustained basis." He based this conclusion on Mr. Fuson's history of symptoms, shortness of breath walking 10 to 12 steps, need for continuous oxygen and chest x-ray findings. Finally, Dr. Stolzfus stated that Mr. Fuson's coal dust induced lung disease contributes to his respiratory impairment.

[33]I take judicial notice of Dr. Baker's board certification and have attached the certification documentation.

[34]On one form, Dr. Baker checked a box indicating Mr. Fusion's pulmonary impairment was "mild." However, he also characterized Mr. Fusion's hypoxemia as "severe" and ultimately concluded that Mr. Fusion was totally disabled.

Dr. D. Matthew Sellers
(DX 16)

On January 7, 2004, Dr. Sellers, board certified in internal medicine, pulmonary diseases and critical care medicine,[35] provided responses to a questionnaire regarding his treatment of Mr. Fuson between January 2002 and March 2003. Dr. Sellers diagnosed chronic obstructive bronchitis. He believes that Mr. Fuson has a chronic dust disease of the lung arising out of coal mine employment based on Mr. Fuson's 28 ½ year coal mine employment history. When presented with the question of whether Mr. Fuson has a totally disabling respiratory impairment and would be able to return to his coal mine employment, Dr. Sellers responded that Mr. Fuson has a disabling impairment that is "more likely limited by age." His conclusion was based pulmonary test results that showed a mild obstruction and Mr. Fuson's advanced age. Dr. Sellers concluded that Mr. Fuson's coal dust induced lung disease "likely contributed to his impairment."

Discussion

Most of the doctors from the 1970s and 1980s diagnosed pneumoconiosis. However, their assessments were insufficient because they relied principally on positive chest x-ray interpretations, considering that the pulmonary test results were normal; whereas, Judge Kichuk determined the radiographic evidence was negative. During the same period, in concluding that Mr. Fuson did not have pneumoconiosis, Dr. Dahhan emphasized the normal pulmonary tests and negative radiographic evidence. While I have considered the earlier medical opinions, I find that due to their dated nature, these assessments have diminished probative weight on whether Mr. Fuson subsequently developed pneumoconiosis. Significantly, none of these physicians were aware of Mr. Fuson's worsening clinical presentation following the 1980s and the more recent abnormal blood gas studies.

In contrast, the opinions of Dr. Stolzfus, Dr. Sellers and Dr. Baker are based on more complete documentation from more recent pulmonary examinations. Although the recently developed radiographic evidence remains inconclusive and non-supportive of their diagnoses of clinical pneumoconiosis, their opinions, and consensus, nevertheless establish the presence of legal pneumoconiosis as defined by 20 C.F.R. § 718.201 (b) since they based their conclusions on other medical factors beyond a positive chest x-ray. Specifically, besides radiographic evidence, Dr. Stolzfus and Dr. Sellers, who had treated Mr. Fuson, based their findings on employment/social histories, clinical presentation, symptomalogy, necessity for therapeutic oxygen assistance, and pulmonary tests. Likewise, in a documented and reasoned opinion, being well aware of Mr. Fuson's social and employment histories, and following a complete pulmonary examination, Dr. Baker attributed Mr. Fuson's severe hypoxemia established by the arterial blood gas study to his long term exposure to coal dust.

In summary, the medical opinions associated with Mr. Fuson's first claim have diminished probative value and remain insufficient to establish the presence of either clinical or legal pneumoconiosis. However, since in their recent evaluations, Dr. Stolzfus, Dr. Sellers, and Dr. Baker relied on other clinical findings besides chest x-ray evidence, their opinions rest on

[35]I take judicial notice of Dr. Sellers' board certification and have attached the certification documentation.

sufficient documentation, are probative, and establish the presence of legal pneumoconiosis as defined by the regulations in Mr. Fuson's lungs. *See Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Accordingly, Mr. Fuson has establish the first requisite element of entitlement, the presence of pneumoconiosis, through medical opinion under 20 C.F.R.§ 718.202 (a) (4).

Pneumoconiosis Arising Out of Coal Mine Employment

Once a claimant has proven the existence of pneumoconiosis, 20 C.F.R. § 718.203 (a) requires that he also establish that his pneumoconiosis arose at least in part from his coal mine employment. According to 20 C.F.R. § 718. 203 (b), if the claimant was employed in coal mining for ten or more years, a rebuttable presumption that the pneumoconiosis is due to coal mine employment exists.

The parties stipulated that Mr. Fuson had at least 19 and a half years of coal mine employment. Additionally, the BRB has affirmed a previous determination of 27 years of coal mine employment. As a result, Mr. Fuson is entitled to the presumption that his pneumoconiosis is related to his coal mine employment. No physician has suggested a cause other than occupational dust exposure for Mr. Fuson's lung disease. As a result, I conclude insufficient evidence exists in the record to rebut the presumption that Mr. Fuson's pneumoconiosis is due to his coal mine employment. Through the un-rebutted presumption, Mr. Fuson has proven that he has coal worker's pneumoconiosis.

Total Disability

As previously mentioned, 20 C.F.R. 718.204 establishes the presence of a totally disabling pulmonary impairment as the third necessary element of entitlement. In his case, by establishing the requisite material change in condition through the preponderance of the arterial blood gas study evidence, as additionally supported by the consensus of the physicians to provide recent opinions on the issue of total disability, Mr. Fuson has proven the third element of entitlement. He has a totally disabling respiratory impairment.

Total Disability Due to Coal Workers' Pneumoconiosis

Because Mr. Fuson has established three of the four requisite elements for entitlement to benefits, the award of benefits rests on the determination of whether his respiratory disability is due to coal workers' pneumoconiosis. Proof that a claimant has a totally disabling pulmonary disease does not by itself establish the impairment is due to pneumoconiosis. Under 20 C.F.R. § 718.204 (c) (1), absent regulatory presumptions in favor of a claimant,[36] the claimant must demonstrate that pneumoconiosis was a substantially contributing cause of his total disability by showing the disease: 1) had a material, adverse effect on his respiratory or pulmonary condition;

[36]20 C.F.R. § 718.304 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption the claimant is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more of coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and, 20 C.F.R. § 718.306 (a presumption exists when a survivor files a claim prior to June 30, 1982).

or, 2) materially worsened a totally disabling respiratory impairment caused by a disease or exposure unrelated to pneumoconiosis. Additionally, 20 C.F.R. § 718.204 (c) (2) mandates that "the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report." The Sixth Circuit requires that the total disability be "due at least in part" to pneumoconiosis. *Adams v. Director, OWCP*, 886 F.2d 818, 825 (6th Cir. 1989) and *Zimmerman v. Director, OWCP*, 871 F.2d 564, 566 (6th Cir. 1998). Further, the claimant must demonstrate that the disease was more than a *de minimis* factor in the miner's total disability. *Peabody Coal Co. v. Smith*, 127 F.3d 504, 507 (6th Cir. 1997).

Returning to the three most recent medical opinions which established the presence of pneumoconiosis, Dr. Seller's disability conclusion has diminished probative value due to its equivocal nature. Although Dr. Seller's linked Mr. Fuson's chronic pulmonary obstruction to his coal dust exposure, the physician also stated that Mr. Fuson's inability to work was most likely caused by advancing age.

On the other hand, both Dr. Stolzfus and Dr. Baker attributed Mr. Fuson's disabling pulmonary condition in part to his coal dust exposure. Their probative assessments on this issue represents the preponderance of the evidence and establishes that Mr. Fuson is totally disabled due to coal workers' pneumoconiosis. Thus, Mr. Fuson has proved the final element of entitlement under 20 C.F.R. § 718.204 (c).

Date of Entitlement

Under 20 C.F.R. § 725.503 (b) in the case of a coal miner who is totally disabled due to pneumoconiosis, benefits are payable from the month of onset of total disability. When the evidence does not establish when the onset of total disability occurred, then benefits are payable starting the month the claim was filed. The BRB has placed the burden on the miner to demonstrate the onset of total disability. *Johnson v. Director, OWCP*, 1 B.L.R. 1-600 (1978). Placing that burden on the claimant makes sense, especially if the miner believes his total disability arose prior to the date he filed his claim. In that case, failure to prove a date of onset earlier than the date of the claim means the claimant receives benefits only from the date the claim was filed. The BRB also stated in *Johnson*, "[c]learly the date of filing is the preferred date of onset unless evidence to the contrary is presented."

Mr. Fuson has not presented evidence that the onset of his total disability occurred before March 2003, when he filed his claim. The arterial blood gas study which established Mr. Fuson's total disability was taken in September 2003. Since the evidence does not establish an earlier onset date of total disability, benefits are payable beginning March 2003, which is the beginning of the month that the claim was filed.

Black lung disability benefits are payable each month and continue through the duration of eligibility. Benefit payments shall terminate the month before the month during which eligibility terminates, 20 C.F.R. 725.502 (c). Since Mr. Fuson died in May 2005, his entitlement to black lung disability benefits expired the month prior, April 2005.

Augmentation

Benefits under the Act may be augmented for a person who meets the criteria of spouse under 20 C.F.R. § 725.204 and the dependency requirements of 20 C.F.R. § 725.205. Based on the parties' stipulation of fact, I find that Mrs. Catherine Fuson is a qualified spouse and meets the regulatory requirements for spousal augmentation of Mr. Fuson's black lung disability benefits.

CONCLUSION

Through a September 2003 qualifying arterial blood gas study, and in the absence of sufficient, probative contrary evidence, Mr. Fuson has established that a change in his pulmonary condition has occurred since the affirmed denial of his previous claim by the Benefits Review Board. Upon consideration of the entire record, the more recent, probative medical opinion established the presence of pneumoconiosis due to his coal mine employment and total disability due to coal workers' pneumoconiosis. Accordingly, Mr. Fuson's claim for black lung disability benefits under the Act must be approved. In accordance with 20 C.F.R. § 725.503 (d), the date of entitlement is March 1, 2003. Since Mr. Fuson passed away in May 2005, his black lung disability benefits terminate April 2005. Mr. Fuson's benefits will be augmented for his spouse, Mrs. Catherine Fuson.

ATTORNEY FEES

Counsel for the Claimant has thirty days from receipt of this decision to submit an additional application for attorney fees related to this case in accordance with 20 C.F.R. § 725.365 and 725.366. With the application, counsel must attach a document showing service of the fee application upon all parties, including the Claimant. The other parties have fifteen days from receipt of the fee application to file an objection to the request. Absent an approved application, no fee may be charged for representation services associated with the claim.

ORDER

The claim of MR. ERNEST FUSON for black lung disability benefits under the Act is **GRANTED**. Benefits shall commence March 1, 2003 and terminate April 1, 2005, augmented for his spouse, Mrs. Catherine Fuson.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: September 26, 2005
Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

Attachment No. 1

American Board of Medical Specialties

Certification:

Manu N. Patel, MD

Certified by the American Board of Radiology in:

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Attachment No. 2

American Board of Medical Specialties

Certification:

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Attachment No. 3

American Board of Medical Specialties

Certification:

Glen Baker, MD

Certified by the American Board of Internal Medicine in:

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Attachment No. 4

American Board of Medical Specialties

Certification:

D. Matthew Sellers, MD

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